ASSOCIATED ADMINISTRATORS, INC.

King County Health Care FSA Reimbursement Request Form

See reverse side for instructions.

Please complete ALL information in this section.

Participant Name		Soc Sec Number
Mailing Address		
New address? ☐ Yes ☐ No	Home Phone (include Area Code)	Work Phone (include Area Code)

Please list expenses for reimbursement in this section.

1	Name for Whom Expense Incurred			Relationship to Plan Participant
	Dates of Service	Begin Date	End Date	$ Amount
2	Name for Whom Expense Incurred			Relationship to Plan Participant
	Dates of Service	Begin Date	End Date	$ Amount
3	Name for Whom Expense Incurred			Relationship to Plan Participant
	Dates of Service	Begin Date	End Date	$ Amount
4	Name for Whom Expense Incurred			Relationship to Plan Participant
	Dates of Service	Begin Date	End Date	$ Amount
			Total Reimbursement Amount	**$**

I understand the Internal Revenue Code permits Health Care Personal Choice Account®/FSA reimbursements only for most tax deductible medical expenses. I have attached written documentation from a doctor, hospital or other medical service provider for each expense listed above. The documentation shows the expenses were incurred by me or my eligible dependents and includes the date(s) the services were received, the type of services and the total expense. I understand neither AAI nor King County shall be responsible for any taxes, interest, penalties or other consequences which may be assessed or arise as a result of any disallowed expenses.

I request reimbursement for the attached expenses under the Health Care Personal Choice Account®/FSA Plan. I certify that I or my eligible dependents have incurred these services and to the best of my knowledge they are reimbursable under the terms of King County's plan. Furthermore, I certify I have not been reimbursed for these expenses from, nor are these expenses reimbursable by, any other source. These expenses have not been and will not be used to claim any federal income tax deduction.

Plan Participant Signature _____ **Date** _____

AAI has tried to make the administration of your Health Care Personal Choice Account®/FSA as straightforward as possible, but reminds you: 1) you must use this form to request reimbursement and 2) Health Care Personal Choice Account® reimbursement dollars are paid directly to you and may not be assigned to any other person.

Submit your completed form to: **Associated Administrators Inc./Personal Choice Account® Unit**
PO Box 3199 - Mail Station B-20F - Portland OR 97208-3199
Fax 1.800.979.8987 ✍ Phone 1.800.334.4340 ✍ E-mail flex@aai-tpa.com

Health Care Reimbursement Request Form Instructions

Here are some reminders for completing this form. Refer to the FSA Guide for more complete details.

1. The expense must be a health related (medical, dental or vision) expense incurred by you or one of your dependents.
2. The expense must be an expense that would have qualified for a tax deduction under the Internal Revenue Code (excluding health and long term care insurance premiums and long term care expenses).
3. Supporting documentation must accompany this request form. Supporting documentation includes the following:
   - An itemized bill showing dates of service, type of service, provider's name, patient's name and amount of service or
   - Copy of any "Explanation of Benefits" (EOB) statement from any insurance plan under which the claimant is covered if it includes the same information as an itemized bill.
   - **Balance forward statements and checks (copies of initial and/or cancelled checks) are not acceptable.**
4. Complete the Health Care FSA Reimbursement form and submit the original along with your supporting documentation to:

   Associated Administrators, Inc.
   Personal Choice Account® Unit
   PO Box 3199 - Mail Station B-20F
   Portland OR 97208-3199
   Fax 1.800.979.8987

5. Retain a copy of the reimbursement request form and copy(ies) of supporting documents for your records. Copies submitted to AAI will not be returned.
6. All reimbursements will be paid by check (mailed to your home address) or direct deposit (notice of direct deposit mailed to your home).
7. If you have questions, please contact the Personal Choice Account® Unit at 1.800.334.4340 or flex@aai-tpa.com.